KAWARTHA THERAPEUTIC CENTRE

86 Russell St. West, Unit 7, Lindsay, ON, K9V6A5
Tel: (705) 878-0463

CONFIDENTIAL PATIENT INFORMATION FORM

Please take a few moments to complete this form as accurately as possible. Your answers will help us determine if we are able help you (and therefore, if we can accept your case). If we believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with the form, please do not hesitate to ask our receptionists.

Name: _____ **Date:** _____
Address: _____
City: _____ **Postal Code:** _____
Home Tel: ( ) _____ **Business Tel: ( )** _____
Date of Birth (D/M/Y): _____ **Age:** _____ **Gender:** ☐ **male** ☐ **female**
Marital Status: ☐ **single** ☐ **married** ☐ **widowed** ☐ **divorced**
☐ **# of children** _____ **Ages:** _____
Occupation: _____
Employer: _____
Extended Health Care Company: _____
How did you hear about our office? ☐ **A friend: if so, who?**_____
☐ **Medical Doctor** ☐ **Sign** ☐ **Ad** ☐ **Website** ☐ **Other:** _____

MEDICAL DOCTOR
Doctor's name: _____
Approximate Date of last appointment: _____**Reason for visit:** _____
Approximate Date of last physical: _____

PRIOR CHIROPRACTIC CARE
Have you ever been to a chiropractor before? ☐ No ☐ Yes
Chiropractor's Name: _____**City:** _____
Reason for attending: _____ **Approximate date last seen:** _____
Were X-rays taken? ☐ No ☐ Yes - Of what area(s) of the body? _____

PLEASE CHECK THE PHRASE THAT MOST REPRESENTS YOUR REASONS FOR CARE:

☐ Symptom relief - i.e. get rid of the pain!

☐ Corrective/Functional Care - i.e. get rid of the pain, but also address any underlying factors that may contribute to my symptoms, or may cause future problems. ex. weak muscles, chronic spinal dysfunction, poor posture, chronic tightness, etc.

☐ Performance/Wellness Care - i.e. I acknowledge that there are many causes of daily repetitive physical stress to my body - keep me performing my best – at home, at work, and/or at play.

DESCRIPTION OF CURRENT INJURY/PAIN

What is your major complaint?_____

_____

What happened? (What is the cause of the problem?) _____

_____

When (what date or how long ago) did you first notice the problem? _____

_____

Please rate the severity of your complaint by checking one box on the below scale.

No Problem	1	2	3	4	5	6	7	8	9	10	Severe Problem

(At best/at worst) _____

_____

Is the complaint constant, frequent or infrequent?_____

When do you notice your complaint the most? _____

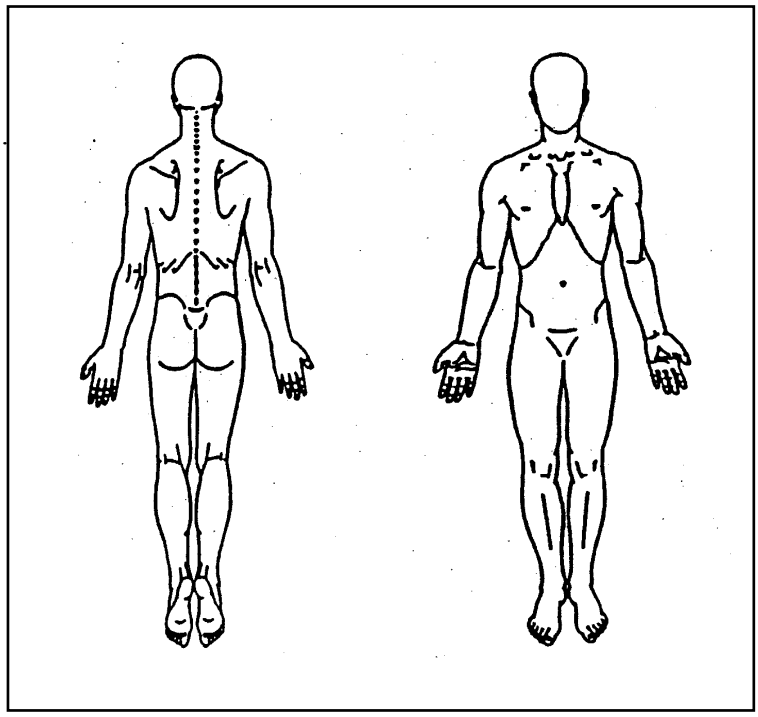
What aggravates your complaint? □ Sitting □Standing □ Bending □ Lifting
□ Walking □ Bed Rest □ Weather Changes □ Other _____

What relieves your complaint? □ Ice □ Heat □ Massage □ Stretches □ Bed Rest
□ Walking □ Medications □ Other_____

Is it getting: □ Worse □ Better □ Constant □ Comes and Goes

Characteristics of the pain:
Using the key below, mark the areas of your body where you feel the described sensations. Use the appropriate symbols. Circle the area if you are unable to describe the sensation. Also mark areas of shooting or radiating symptoms. Include all affected areas:

XXX = Sharp Pain
TTT = Tense/Tight
BBB = Burning
AAA = Ache
+++ = Pins& Needles
/// = Numbness
->->-> = Radiates
OOO = Other (describe)



What treatments have you had for this problem? □ Chiropractic □ Physical Therapy □ Massage
□ Medical Treatment □ Acupuncture □ Other Procedures _____

Have you ever had this or a similar problem before? _____

Do you have any other (secondary) complaints? _____

_____

_____

Have you had any diagnostic studies? □ X-rays □ CT scans □ MRI scans
□Lab work □ EMG's □ Other _____

How does this problem affect your life with respect to:
Your ability to work?_____
Your ability to enjoy family/social time? _____
Your ability to enjoy activities/ sports? _____

GENERAL HEALTH

Compared to 5 years ago, would you say your overall health is: □ better □ staying the same □ worse
Overall Stress Levels: □ high □ med-high □ medium □ med-low □ low
Medications you currently take: □ Painkillers □ Muscle Relaxants □ Blood Pressure meds
□ Heart Meds □ Insulin □ For Indigestion □For Depression □ For Anxiety
□ For Asthma □ For Allergies □ HRT □ Other _____
□Over the counter drugs _____
Natural supplements you currently take: □ Multivitamin □ Vitamin C □ B-complex vitamins
□ Calcium □ Omega3/6/9 □ Prenatal vitamin □Folic Acid □Glucosamine
□ Homeopathic remedies □ Naturopathic remedies □ Other _____
What is your personal satisfaction with your diet?
□ Highly satisfied □ Satisfied □ Dissatisfied □ Highly Dissatisfied Why? _____
_____
Do you have a regular exercise program? □ No □Yes What type, and how often? _____
_____
Do you wear orthotics? □ Yes □ No
Do you use tobacco? □ No □ Yes - Amount: _____ □ In the past - year you quit? _____
Do you use alcohol? □No □ Yes – Occasionally □ Yes – Regularly
Do you suffer from any other health conditions? □ No □ Yes (please list) _____
_____
_____

PAST HEALTH HISTORY

Please check off any hospitalizations or surgical operations and state the approximate dates:
□ Appendectomy_____ □ Tonsillectomy_____ □ Gall Bladder _____ □ Hernia _____ □ C-Section _____
□Hysterectomy _____ □ Back Surgery _____ □ Broken Bones _____
□Labour& Delivery _____
□Other Hospitalizations/surgeries _____
Please describe any previous traumas and approximate dates:
□ Motor vehicle accidents_____
□ Sports injuries_____
□Work Injuries _____
□ Falls _____
□ Childhood Traumas_____
Was your own birth: □ C-section □ Forceps delivery □ Natural delivery □Breech □ Don't Know

The follow is a list of conditions, which may seem unrelated to your current complaint. However, we would like to assess your full health picture, and some of these conditions can also be affected by your overall courses of care. Please check the appropriate box for any of the following symptoms which you have now or have experienced previously. **C= currently P= previously**

C P
- ☐ ☐ Diabetes
- ☐ ☐ Loss of consciousness
- ☐ ☐ Blackouts/fainting
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness
- ☐ ☐ Headaches
- ☐ ☐ Loss of sleep
- ☐ ☐ Fever
- ☐ ☐ Sweats
- ☐ ☐ Clumsiness
- ☐ ☐ Loss of balance
- ☐ ☐ Numbness in arm/hand
- ☐ ☐ Numbness in leg/foot
- ☐ ☐ Depression
- ☐ ☐ Fatigue
- ☐ ☐ Anxiety
- ☐ ☐ Forgetfulness
- ☐ ☐ Allergies
- ☐ ☐ Recent weight gain
- ☐ ☐ Recent weight loss

SKIN
C P
- ☐ ☐ Itching
- ☐ ☐ Skin rash
- ☐ ☐ Bruises easily
- ☐ ☐ Psoriasis
- ☐ ☐ Varicose veins

MUSCLE & JOINT
C P
- ☐ ☐ Osteoporosis
- ☐ ☐Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Swollen joints
- ☐ ☐ Foot trouble
- ☐ ☐ Hernia
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain
- ☐ ☐ Neck stiffness
- ☐ ☐ Pain in the joints
- ☐ ☐ Weakness
- ☐ ☐ Jaw pain/TMJ

CARDIOVASCULAR
C P
- ☐ ☐ Aneurysm
- ☐ ☐ Angina
- ☐ ☐ Bleeding disorder
- ☐ ☐ High blood pressure
- ☐ ☐ Pain over the heart
- ☐ ☐ Stroke
- ☐ ☐ Heart attack
- ☐ ☐ Ankle swelling

EYES, EARS, NOSE& THROAT
C P
- ☐ ☐ Wear glasses/contacts
- ☐ ☐ Blurred/double vision
- ☐ ☐ Eye pain
- ☐ ☐ Deafness
- ☐ ☐ Ear aches
- ☐ ☐ Ringing or buzzing in ears
- ☐ ☐ Sinus infections
- ☐ ☐ Enlarged glands
- ☐ ☐ Enlarged thyroid
- ☐ ☐ Difficulty swallowing

GENITO-URINARY
C P
- ☐ ☐ Bed wetting
- ☐ ☐ Painful urination
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Loss control urine
- ☐ ☐ Kidney infection
- ☐ ☐ Prostate trouble

LUNG&BREATHING
C P
- ☐ ☐ Asthma
- ☐ ☐ Difficulty breathing
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Wheezing
- ☐ ☐ Spitting phlegm
- ☐ ☐ Splitting blood

GASTROINTESTINAL
C P
- ☐ ☐ Poor appetite
- ☐ ☐ Loss of weight
- ☐ ☐ Indigestion
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Vomiting blood
- ☐ ☐ Pain over stomach
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Ulcer
- ☐ ☐ Jaundice

WOMEN ONLY
C P
- ☐ ☐ Painful menstruation
- ☐ ☐ PMS
- ☐ Pregnant
  Due date_____

# of pregnancies _____
# of children _____

FAMILY HEALTH HISTORY

What is your family medical history? What medical problems do your parents or siblings have? Please list relationship and problem: (ex: Peter – Father - diabetes)

Name	Relationship	Past & Present Health Problems

FEMALES ONLY

Is there any possibility that you might be pregnant? ☐ Yes ☐No ☐Maybe

Are you Menopausal? ☐ Yes ☐No